STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
K0000	A Life Safety Code Recertification and State Licensure Survey was conducted by the Indiana State Department of Health in accordance with 42 CFR 483.70(a). Survey Date: 10/17/11 and 10/18/11 Facility Number: 000032 Provider Number: 155077 AIM Number: 100273330 Surveyor: Mark Caraher, Life Safety Code Specialist At this Life Safety Code survey, Lakeview Manor Inc. was found not in compliance with Requirements for Participation in Medicare/Medicaid, 42 CFR Subpart 483.70(a), Life Safety from Fire and the 2000 Edition of the National Fire Protection Association (NFPA) 101, Life Safety Code (LSC), Chapter 19, Existing Health Care Occupancies and 410 IAC 16.2. This one story facility was determined to be of Type III (211) construction and was fully sprinklered. The facility has a fire alarm system with smoke detection in the corridors, areas open to the corridors and rooms 11 through 19 in the C Hall. The facility has a capacity of 184 and had a	K0000	Submission of this Plan of correction does not constitute an admission to or an agreement with facts alleged on the survey report. Submission of this Plan of Correction does not constitute an admission or an agreement by the provider of the truth of facts alleged or corrections set forth on the statement of deficiencies. The Plan of Correction is prepared and submitted because of requirements under State and Federal law. Please accept this Plan of Correction as our credible allegation of compliance.	

LABORATORY DIRECTOR'S OR PROVIDER/SUPPLIER REPRESENTATIVE'S SIGNATURE | TITLE | (X6) DATE

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	census of 142 at the time of this survey. Quality Review by Robert Booher, Life Safety Code Specialist-Medical Surveyor on 10/21/11. The facility was found not in compliance with the aforementioned regulatory requirements as evidenced by the following:			
K0029 SS=E	One hour fire rated construction (with ¾ hour fire-rated doors) or an approved automatic fire extinguishing system in accordance with 8.4.1 and/or 19.3.5.4 protects hazardous areas. When the approved automatic fire extinguishing system option is used, the areas are separated from other spaces by smoke resisting partitions and doors. Doors are self-closing and non-rated or field-applied protective plates that do not exceed 48 inches from the bottom of the door are permitted. 19.3.2.1 Based on observation and interview, the facility failed to ensure 2 of 10 doors serving hazardous areas such as the kitchen are provided with a positive latching device to latch the door into the door frame. This deficient practice could affect any resident, staff or visitor in the vicinity of the east and west entry doors to the kitchen from the Main Dining Room. Findings include:	K0029	K 029 I. Both the east and west kitchen entry doors have been replaced with doors that contain positive latching devices. II. All residents, staff and visitors in the vicinity of the east and west kitchen entry doors have the potential to be affected. III. An audit of all entry doors into hazardous areas was conducted to ensure all doors contain a positive latching device. No further deficiencies were noted.	11/11/2011

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	Based on observation with the Maintenance Director during a tour of the facility from 9:00 a.m. to 10:55 a.m. on 10/18/11, the east and west kitchen entry doors from the Main Dining Room are not equipped with a positive latching device to latch each door into the door frame. Based on interview at the time of observation, the Maintenance Director acknowledged the east and west entry doors to the kitchen from the Main Dining Room are each not equipped with a positive latching mechanism to latch the door into the door frame. 3.1-19(b)		IV. As a means of quality assurance, all entry doors into hazardous areas will be checked for proper latching weekly and findings noted on the weekly preventative maintenance log. Should noncompliance be noted, corrective action shall be implemented. Results of the aforementioned audits and immediate corrective actions taken shall be reported to the quality assurance committee on a quarterly basis for review and recommended revision of monitoring, if warranted.	
K0048 SS=E	There is a written plan for the protection of all patients and for their evacuation in the event of an emergency. 19.7.1.1 Based on record review and interview, the facility failed to include the use of kitchen fire extinguishers in the written fire safety plan for the facility in the event of an emergency to protect 142 of 142 residents. LSC 19.7.2.2 requires a written health care occupancy fire safety plan that shall provide for the following: (1) Use of alarms (2) Transmission of alarm to the fire department (3) Response to alarms	K0048	K 048 The facility fire and disaster plan has been reviewed and revised to address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. As all residents/staff could be affected, the following corrective action will be taken:	11/03/2011

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	(4) Isolation of fire (5) Evacuation of immediate area (6) Evacuation of smoke compartment (7) Preparation of floors and building for evacuation (8) Extinguishment of fire This deficient practice affects any resident, staff and visitors in the vicinity of the kitchen. Findings include: Based on a review of the facility's written fire disaster plan titled "Disaster Manual: Fire Disaster Plan" for Lakeview Manor, Inc. during record review with the Maintenance Director from 9:40 a.m. to 12:10 p.m. on 10/17/11, the fire disaster plan did not address the use of ABC type fire extinguishers and the K class fire extinguisher located in the kitchen in relationship with the use of the kitchen overhead extinguishing system. Based on an interview at the time of record review, the Maintenance Director acknowledged the written fire safety plan for the facility did not include kitchen staff training to activate the overhead hood extinguishing system to suppress a fire before using either the ABC type fire extinguisher or the K class fire extinguisher.		As a means to ensure ongoing compliance with maintaining a written plan for the protection of all residents and for their evacuation in the event of an emergency, the fire and disaster plan has been reviewed and revised and dietary staff will receive appropriate training for adherence therewith. The revised fire and disaster plan will be addressed during initial orientation of dietary staff and periodically thereafter. As a means of quality assurance, the fire and disaster plan will be reviewed by administrative staff on, at least, an annual basis with review and revision ongoing should concerns be identified and/or need of revision be identified.	

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K0052 SS=F	3.1-19(b) A fire alarm system required for life safety is installed, tested, and maintained in accordance with NFPA 70 National Electrical Code and NFPA 72. The system has an approved maintenance and testing program complying with applicable requirements of NFPA 70 and 72. 9.6.1.4 Based on record review and interview, the facility failed to ensure the documentation for the testing of 2 of 35 smoke detectors and 8 of 8 fire alarm boxes was complete. LSC 9.6.1.4 refers to NFPA 72, National Fire Alarm Code. NFPA 72 at 7-1.1.1 states inspection, testing, and maintenance programs shall satisfy the requirements of this Code, shall conform to the equipment manufacturer's recommendations, and shall verify correct operation of the fire alarm system. NFPA 72, 7-3.2 requires fire alarm system initiation devices such as smoke detectors and fire alarm boxes be functional tested annually. This deficient practice could affect any resident, staff and visitor in the facility. Findings include: a. Based on a review of General Alarm "Smoke Detector Test Report" documentation dated 01/31/11 during record review with the Maintenance	K0052	K052 I. All smoke detectors and pull stations were re-tested on October 19, 2010. Smoke detectors #18 and #31 were involved in this test. All smoke detectors and pull stations passed the testing. A detailed report listing ID#, Brand/Model, Location, Listed Sensitivity Range, Tested Sensitivity, Pass/Fail, and recalibration/replacement was completed for all smoke detectors. A detailed report listing type of device, location, tested by, and results was completed for all pull stations. II. All residents, staff and visitors have the potential to be affected III. As a means of quality assurance, the Maintenance Director will accompany the vendor during the annual testing. The Administrator will review the vendor's detailed report to ensure	11/11/2011

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	Director from 9:40 a.m. to 12:10 p.m. on 10/17/11, the annual smoke detector functional test for the C Hall smoke detector identified as # 18 and the Main Dining Room smoke detector identified as # 31 were not stated as pass or fail. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no documentation to state the C Hall smoke detector identified as # 18 and the Main Dining Room smoke detector identified as # 31 passed an annual functional test. b. Based on a review of General Alarm "Inspection and Testing Form" documentation dated 02/08/11 during record review with the Maintenance Director from 9:40 a.m. to 12:10 p.m. on 10/17/11, the annual functional test report for eight of eight facility fire alarm boxes did not state the location of each fire alarm box and did not state if the results of the functional test was pass or fail. Based on interview at the time of record review, the Maintenance Supervisor acknowledged there was no functional test report documentation to state the location of each fire alarm box in the facility and if each fire alarm box passed the annual functional test. 3-1.19(b)		all smoke detectors and pull stations have been tested and the report is complete with locations and pass/fail ratings.	

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K0062 SS=F	Required automatic sprinkler systems are continuously maintained in reliable operating condition and are inspected and tested periodically. 19.7.6, 4.6.12, NFPA 13, NFPA 25, 9.7.5 Based on record review and interview, the facility failed to ensure quarterly sprinkler inspections were conducted for the sprinkler system for 1 of 4 calendar quarters. NFPA 25, Standard for the Inspection, Testing, and Maintenance of Water-Based Fire Protection Systems, 1-8 requires records of inspections and tests of the sprinkler system and its components shall be made available to the authority having jurisdiction upon request. This deficient practice could affect 142 of 142 residents, all staff, and visitors in the facility. Findings include: Based on a review of Dalmatian Fire Services "Form for Inspection, Testing and Maintenance of Fire Sprinkler Systems" documentation with the Maintenance Director during record review from 9:40 a.m. to 12:10 p.m. on 10/17/11, no first quarter 2011 (January, February, March) quarterly sprinkler system inspection documentation was available for review. Based on interview	K0062	I. The facility's fire sprinkler system was inspected on October 24, 2011. All aspects of the fire sprinkler system were found to be in good working order. II. All residents, staff and visitors have the potential to be affected. III. As a means of quality assurance, the quarterly fire sprinkler system inspections are listed as part of the facilities quarterly preventative maintenance program. The maintenance director or designee will review the inspections to insure that inspections have been completed quarterly. Corrective action will be taken immediately if inspections are found not to be complete. IV. Quarterly inspection log will also be reviewed during the facility's quarterly quality assurance meeting.	11/11/2011

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	at the time of record review, the Maintenance Director acknowledged a first quarter 2011 sprinkler system inspection documentation was not available for review. 3.1-19(b)			
K0076 SS=E	Medical gas storage and administration areas are protected in accordance with NFPA 99, Standards for Health Care Facilities. (a) Oxygen storage locations of greater than 3,000 cu.ft. are enclosed by a one-hour separation. (b) Locations for supply systems of greater than 3,000 cu.ft. are vented to the outside. NFPA 99 4.3.1.1.2, 19.3.2.4 1. Based on observation and interview, the facility failed to ensure 1 of 1 exterior oxygen supply storage locations was protected from extremes of weather. NFPA 99, 4-3.5.2.2 requires cylinders stored in the open shall be protected against extremes of weather. During winter, cylinders stored in the open shall be protected from an accumulation of ice or snow. In summer, cylinders stored in the open shall be screened against continuous exposure to direct rays of the sun in those localities where extreme temperatures prevail. This deficient practice could affect any resident, staff or	K0076	K 076 I. 1. A roof type structure has been constructed for the exterior chain link enclosure housing 5 180 liter liquid oxygen tanks. This structure will ensure that the tanks are protected from sun, snow and rain. 2. All five of the listed cylinders have been secured with either chain or cylinder carts 3. An additional 1 inch of drywall has been added to the ceiling of the oxygen storage area, bringing the total thickness of the ceiling to 1.5 inches and thus creating a fire rating of 1 hour or longer.	11/11/2011

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	visitor in the vicinity of the exterior oxygen supply location near the vestibule exit from the B Hall. Findings include: Based on observation during a tour of the facility with the Maintenance Director from 1:00 p.m. to 3:40 p.m. on 10/17/11, five 180 liter liquid oxygen tanks were located in an exterior chain link enclosure outside the facility near the vestibule exit from the B Hall. The enclosure was not protected from sun, snow, or rain. Based on interview at the time of observation, the Maintenance Director acknowledged liquid oxygen storage tanks in the exterior oxygen supply storage location were not protected from extremes of weather. 3.1-19(b) 2. Based on observation and interview, the facility failed to ensure 5 of 20 cylinders of nonflammable gases such as oxygen were chained or supported in a cylinder stand or cart. NFPA 99, Health Care Facilities, 8-3.1.11.2(h) requires cylinder or container restraint shall meet NFPA 99, 4-3.5.2.1(b)27 which requires freestanding cylinders be properly chained or supported in a proper cylinder stand or cart. This deficient practice could affect any resident, staff or visitor in the vicinity		II. All residents, staff, and visitor within the vicinity of the oxygen storage areas have the potential to be affected III. Respiratory manager will conduct daily rounds of all oxygen storage areas to ensure all cylinders are secure and that cylinders are not exposed to extreme weather conditions. Should non-compliance be noted corrected action will taken immediately IV. As a means of quality assurance, the maintenance director or designee will check all oxygen storage areas as part of the facilities monthly preventative maintenance program. Should non-compliance be noted, corrected action will be taken immediately. Findings will be reviewed during the facilities quality assurance meeting.	

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	of the oxygen storage and transfilling room. Findings include: Based on observation during a tour of the facility with the Maintenance Director and the Respiratory Therapist during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 10/17/11, five "E" type oxygen cylinders were standing in an area of the oxygen storage and transfilling room labeled "Cylinder Full" without support. Based on interview at the time of observation, the Respiratory Therapist acknowledged five of the twenty E type cylinders in the oxygen storage and transfilling room were not chained or supported in a cylinder stand or cart. 3.1-19(b) 3. Based on observation and interview, the facility failed to ensure 1 of 1 oxygen storage locations of greater than 3000 cubic feet was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. NFPA 99 section 8-3.1.11.1 requires storage for nonflammable gases shall comply with 4-3.1.1.2. NFPA 99 section 4-3.1.1.2(a)2 requires at least one hour fire resistant enclosures shall be			

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	provided for the storage of oxidizing agents such as oxygen. This deficient practice could affect any resident, staff or visitor in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 1:00 p.m. to 3:40 p.m. on 10/17/11, the oxygen storage and transfilling room contained seven liquid oxygen canisters. The ceiling was constructed of one layer of one half inch thick drywall board which did not provide a fire resistive construction of one or more hours. Based on interview at the time of observation, the Maintenance Director stated the ceiling was constructed of one layer of one half inch thick drywall board and acknowledged the one layer of one half inch thick drywall board did not provide one hour fire resistive construction. 3.1-19(b)			
K0130 SS=E	OTHER LSC DEFICIENCY NOT ON 2786 Based on observation and interview, the facility failed to ensure 2 of 3 fuel fired	K0130	K 130 I. Both identified water heaters have been inspected.	11/11/2011

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	water heaters had inspection certificates which were current to ensure the water heaters were in safe operating condition. NFPA 101 in 19.1.1.3 requires all health facilities to be designed constructed, maintained and operated to minimize the possibility of a fire emergency requiring the evacuation of occupants. This deficient practice could affect any resident, staff or visitors in the vicinity of the Main Shut-Off Electrical and Water Room. Findings include: Based on observation with the Maintenance Director during the tour of the facility from 1:00 p.m. to 3:40 p.m. on 10/17/11, the inspection certificates for two of the three fuel fired water heaters in the Main Shut-Off Electrical and Water Room had expired certificates. The natural gas fired water heater identified as 301826 had a certificate expiration date of 12/12/10 and the natural gas fired water heater identified as 297028 had a certificate expiration date of 07/07/11. Based on interview at the time of observation, the Maintenance Director stated no updated certificate for either natural gas fired water heater was available for review and acknowledged the inspection certificates had expired certification dates.		Both were found to be in good working order. All water heaters have been inspected and have current inspection certificates. II. Maintenance director or designee will review all water heater certificates monthly to ensure they are current. Maintenance Director will call for inspection of all water heaters 60 days prior to expiration date to ensure certificates are obtained timely.	

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	3.1-19(b)			
K0143 SS=E	Transferring of oxygen is: (a) separated from any portion of a facility wherein patients are housed, examined, or treated by a separation of a fire barrier of 1-hour fire-resistive construction; (b) in an area that is mechanically ventilated, sprinklered, and has ceramic or concrete flooring; and (c) in an area posted with signs indicating that transferring is occurring, and that smoking in the immediate area is not permitted in accordance with NFPA 99 and the Compressed Gas Association. 8.6.2.5.2 Based on observation and interview, the facility failed to ensure 1 of 1 areas where transferring of oxygen takes place was separated from any portion of a facility wherein residents are housed, examined, or treated by a separation of a fire barrier of 1 hour fire resistive construction. This deficient practice could affect residents, staff and visitors in the vicinity of the oxygen storage and transfilling room. Findings include: Based on observation with the Maintenance Director during a tour of the	K0143	K143 I. An additional 1 inch of drywall has been added to the ceiling of the oxygen storage area, bringing the total thickness of the ceiling to 1.5 inches and thus creating a fire rating of 1 hour or longer. II. All residents, staff, and visitor within the vicinity of the oxygen storage areas have the potential to be affected All areas in which transferring of oxygen occurs now meet proper fire rating	11/11/2011

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	facility from 1:00 p.m. to 3:40 p.m. on 10/17/11, the oxygen storage and transfilling room contained seven liquid oxygen canisters. The oxygen storage and transfilling room had a sign on the door stating the room was an oxygen storage and transfilling room. The ceiling was constructed of one layer of one half inch thick drywall board which did not provide a fire resistive construction of one hour. Based on interview at the time of observation, the Maintenance Director stated the ceiling was constructed of one layer of one half inch thick drywall board and acknowledged the one layer of one half inch thick drywall board did not provide one hour fire resistive construction. 3.1-19(b)			
K0144 SS=F	Generators are inspected weekly and exercised under load for 30 minutes per month in accordance with NFPA 99. 3.4.4.1. Based on observation and interview, the facility failed to ensure 1 of 1 emergency generators was equipped with a remote manual stop. NFPA 99, Health Care Facilities, 3-4.1.1.4 requires generator sets installed as alternate power sources shall meet the requirements of NFPA 110,	K0144	K144 I. A remote manual stop station has been added to the facility generator II. All residents, staff and visitors have the ability to be affected. III. As a means to ensure ongoing compliance the remote	11/11/2011

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
	155077	A. BUILDING 01 B. WING	10/18/2011

NAME OF PROVIDER OR SUPPLIER	STREET ADDRESS, CITY, STATE, ZIP CODE
LAKEVIEW MANOR	45 BEACHWAY DR INDIANAPOLIS, IN46224

(X4) ID PREFIX TAG	SUMMARY STATEMENT OF DEFICIENCIES (EACH DEFICIENCY MUST BE PERCEDED BY FULL REGULATORY OR LSC IDENTIFYING INFORMATION)	ID PREFIX TAG	PROVIDER'S PLAN OF CORRECTION (EACH CORRECTIVE ACTION SHOULD BE CROSS-REFERENCED TO THE APPROPRIATE DEFICIENCY)	(X5) COMPLETION DATE
	Standard for Emergency Standby Power Systems. NFPA 110, 3-5.5.6 requires Level II installations shall have a remote manual stop station of a type similar to a break glass station located outside of the room where the prime mover is located. NFPA 110, 7-1 states NFPA 37, Standard for the Installation and Use of Stationary Combustion Engines and Gas Turbines, contains mandatory requirements for emergency generators and shall be considered part of the requirements of this standard. NFPA 37, 8-2.2(c) requires emergency generators of 100 horsepower of more have provisions for shutting down the engine at the engine and from a remote location. This deficient practice could affect all residents, staff and visitors. Findings include: Based on observation with the Maintenance Director during a tour of the facility from 1:00 p.m. to 3:40 p.m. on 10/17/11, no evidence of a remote shut off device was found for the 600 kW diesel fired emergency generator. Based on interview at the time of observation, the Maintenance Director stated the emergency generator was installed in 1990 and acknowledged there is no remote emergency shut off device for the emergency generator.		manual stop station will be monitored for proper functioning. Should any non-compliance occur, corrective action will be taken immediately.	

STATEMENT OF DEFICIENCIES AND PLAN OF CORRECTION	(X1) PROVIDER/SUPPLIER/CLIA IDENTIFICATION NUMBER:	(X2) MULTIPLE CONSTRUCTION	(X3) DATE SURVEY COMPLETED
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	3.1-19(b)			